STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041089	A. BUILDING: _____ B. WING _____	R 12/04/2025

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RICHLAND SQUARE	3823 LAWNDALE DRIVE GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 12/02/25 to 12/04/25.	D 000	10A NCAC 13F .1004 (a) Medication Admin. ED, DCS or designee will audit complete a MAR to CART audit to ensure medications are available as ordered. Complete: 1/15/26	
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 2 of 5 sampled residents (#2, #3) including a medication used to manage pain (#2) and a medication used to prevent constipation (#3). The findings are: 1. Review of Resident #2's current FL2 dated 08/20/25 revealed: -Diagnoses included Alzheimer's disease, Lyme disease, hypothyroidism, sleep disorder, hearing loss, and cognitive communication deficit. -He was intermittently confused. Review of Resident #2's signed physician order dated 10/22/25 revealed there was an order for Lidocaine 4% topical pain patch apply 1 patch to left knee once in the morning and remove in the evening leave on for 12 hours then take off daily.	D 358	ED, DCS or designee will conduct random checks of medications on cart to match MAR weekly for 1 month. Complete: 1/30/26 Type text here ED, DCS or designee will conduct random med pass audits to check medications are given as ordered for each medtech passing medications. Complete: 1/30/26 ED, DCS or designee will conduct inservice with medtechs reviewing medication administration rule .1004 (a) Complete: 1/30/26	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
ED 12.31.2025

Reviewed and Acknowledged K.M. 01/05/26

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D 358	Continued From page 1 Review of Resident #2's October 2025 electronic medication administration record (eMAR) from 10/22/25-10/29/25 revealed there were no entries for Lidocaine 4% topical pain patch apply 1 patch to left knee once in the morning and remove in the evening leave on for 12 hours then take off daily. Review of Resident #2's November 2025 and December 2025 (12/01-12/02/25) revealed entries for Lidocaine 4% topical pain patch apply 1 patch to left knee once in the morning and remove in the evening leave on for 12 hours then take off daily. Observations of Resident #2's medications on hand on 12/03/25 at 2:14pm revealed there were no Lidocaine 4% topical patches on hand for administration. Interview with Resident #2 on 12/04/25 at 10:24am revealed he thought staff put pain patches on his knee every day but could not be sure. Telephone interview with Resident #2's family member on 12/04/25 at 9:44am revealed: -She was previously using the facility's contracted pharmacy to provide Resident #2's medications but had requested to have Resident #2's pharmacy supply his medications beginning in September 2025. -No one from the facility ever reported they did not have Resident #2's Lidocaine 4% topical pain patches but facility staff had reported long delays in receiving medications from Resident #2's pharmacy. -She had never supplied Lidocaine 4% topical pain patches for Resident #2.	D 358		

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D 358	Continued From page 2 Telephone interview with a representative from Resident #2's pharmacy on 12/03/25 at 3:04pm revealed there was no active order for Lidocaine 4% topical pain patch apply 1 patch to left knee once in the morning and remove in the evening leave on for 12 hours then take off daily for Resident #2 in the previous 999 days. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/03/25 at 3:45pm revealed: -Primary Care Providers (PCPs) electronically prescribed new orders to the pharmacy for entry and the pharmacy was responsible for all entries onto eMARs. -There was an active order for Resident #2's Lidocaine 4% topical pain patches dated 10/22/25. -There was only one dispense date on 12/03/25 for a quantity of 30. -He was unaware of why the pain patches were not dispensed before 12/03/25. Telephone interview with Resident #2's PCP on 12/04/25 at 10:58am revealed: -She provided care to Resident #2 along with another provider who visited him monthly. -She was aware that Resident #2 did not receive his Lidocaine 4% pain patches for almost one week after she prescribed them because Resident #2's pharmacy had a long delay in delivering them. -She sent the order electronically to the facility's contracted pharmacy on 10/22/25 because they were responsible for adding new orders to eMARs. -She felt the facility's contracted pharmacy should have dispensed them to avoid a delay from Resident #2's pharmacy.	D 358		

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D 358	Continued From page 3 -Resident #2 was likely uncomfortable without the pain patches but he removed them himself often. -Resident #2's prescribed oral pain medication should cover his pain, and she only ordered the pain patches because Resident #2's family member wanted the dosage of his oral pain medication reduced. Interview with a medication aide (MA) on 12/04/25 at 1:26pm revealed: -She was aware of the order for Lidocaine 4% pain patches for Resident #2. -She was aware that Resident #2 was out of pain patches and she reported this to the facility's Resident Care Coordinator (RCC) several times over the past two weeks. -Resident #2 complained of knee pain daily. -The facility's Director of Clinical Services (DCS) contacted the facility's contracted pharmacy the previous night to obtain the pain patches. Attempted telephone interview with the RCC on 12/04/25 at 2:27pm but was unsuccessful. Interview with the DCS on 12/04/25 at 10:39am revealed: -She was aware of the order for Lidocaine 4% pain patches for Resident #2 and was aware that there were no pain patches on the medication cart. -MAs ordered all medication refills through the eMAR system. -If a medication was not delivered within 24 hours following the refill request, MAs should notify her so she could contact a local back up pharmacy to obtain the medication. -The RCC conducted medication cart audits at least monthly. -No one had completed medication order audits since she began employment at the facility in	D 358		

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D 358	Continued From page 4 August 2025. -Resident #2 had a local visitor who may have supplied Lidocaine 4% pain patches in the past because she had picked up other medication for him. Interview with the Administrator on 12/04/25 at 2:01pm revealed: -She was aware of Resident #2's order for Lidocaine 4% pain patches but was unaware that he had none on the medication cart. -The facility's contracted pharmacy completed all order entries on the eMAR. -MAs were supposed to reorder medications and report to the RCC if medications were not delivered. -The RCC and DCS were supposed to complete medication cart audits monthly and monthly medication-to-eMAR audits, but she was unaware of the last completion date for these audits. -She expected MAs to reorder medications and report to the RCC if medications were not delivered within 24 hours. -She expected all residents' medications to be administered as ordered. 2. Review of Resident #3's current FL2 dated 01/16/25 revealed: -Diagnoses included dementia, hypertension, prolonged QT interval and pulmonary nodule. -She was constantly confused. Review of Resident #3's signed physician orders dated 07/10/25 revealed there was an order for polyethylene glycol 3350 in 17 gram packets mix 1 pack in 8 ounces of fluid and drink once daily. Review of Resident #3's October 2025, November 2025 and December 2025 (12/01/25 and 12/02/25) revealed entries for polyethylene	D 358		

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D 358	Continued From page 5 glycol 3350 17-gram packets mix 1 pack in 8 ounces of fluid and drink once daily. Observations of Resident #3's medications on hand on 12/03/25 at 2:24pm revealed there were no polyethylene glycol 3350 in 17 gram packets on hand for administration. Based on observations, record reviews and staff interviews, it was determined that Resident #3 was not interviewable. Attempted telephone interview with Resident #3's family member on 12/04/25 at 1:24pm but was unsuccessful. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/03/25 at 3:45pm revealed: -Primary Care Providers (PCPs) sent new orders electronically for the pharmacy staff to enter them onto eMARs. -There was an active order for Resident #3's polyethylene glycol 3350 in 17 gram packets mix 1 pack in 8 ounces of fluid and drink once daily dated 10/18/24. -There was only one dispense date on 09/22/25 for a quantity of 30 to provide a 30 day supply. -He could not determine why the medication was only dispensed once. -If the medication was dispensed as ordered, the last dose would have been given on 10/22/25. Telephone interview with Resident #3's PCP on 12/04/25 at 10:58am revealed: -Resident #3 had an order for polyethylene glycol 3350 in 17gram packets mix 1 pack in 8 ounces of fluid and drink once daily. -She was unaware that the medication was not on hand for administration until 12/03/25.	D 358		

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D 358	Continued From page 6 -She was unaware that the facility's contracted pharmacy had only dispensed the medication one time. -She sent the order electronically to the facility's contracted pharmacy on 10/18/24 because they were responsible for adding new orders to eMARs. -Facility staff had never reported Resident #3 being constipated. -As long as Resident #3 was having regular bowel movements, she was not concerned about her not having the medication because she also took another medication containing both a stimulant laxative and a stool softener. -She expected all resident medications to be administered as ordered. Interview with a medication aide (MA) on 12/04/25 at 1:34pm revealed: -She was aware of Resident #3's order for polyethylene glycol 3350 17-gram packets. -She was unaware that the medication was not available for administration until 12/03/25. -She contacted the facility's contracted pharmacy electronically when a medication was unavailable and would also call the pharmacy by phone if the medication was not delivered timely or if the medication was a narcotic. -She contacted the facility's contracted pharmacy electronically on 12/03/25 to request a refill of the polyethylene glycol 3350 in 17 gram packets. -She reported to the Resident Care Coordinator (RCC) when a resident was out of medication but did not do so for the polyethylene glycol because the RCC was off on 12/03/25. -Resident #3 had no problems with bowel movements. Attempted telephone interview with the RCC on 12/04/25 at 2:27pm but was unsuccessful.	D 358		

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D 358	Continued From page 7 Interview with the Director of Clinical Services (DCS) on 12/04/25 at 1:45pm revealed: -She was aware of the order for polyethylene glycol 3350 in 17 gram packets for Resident #3 but was unaware that there were no packets on the medication cart. -MAs ordered all medication refills through the eMAR system and notified the RCC if the medication was not delivered within 24 hours. -The RCC should contact both the pharmacy and the DCS when medications run out. -The RCC conducted medication cart audits at least monthly. -No one had completed medication order audits since she began employment at the facility in August 2025. Interview with the Administrator on 12/04/25 at 2:01pm revealed: -She was aware of Resident #3's order for polyethylene glycol 3350 in 17 gram packets but was unaware that she had none on the medication cart. -The facility's contracted pharmacy completed all order entries on the eMAR. -MAs were supposed to reorder medications and report to the RCC if medications were not delivered. -The RCC and DCS were supposed to complete medication cart audits monthly and monthly medication-to-eMAR audits, but she was unaware of the last completion date for these audits. -She expected MAs to reorder medications and report to the RCC if medications were not delivered within 24 hours. -She expected all residents' medications to be administered as ordered.	D 358		

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D 367	Continued From page 8	D 367	10A NCAC 13F .1004 (j) Medication Administration	
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#4) including documentation of a blood thinner and a bronchodilator. The findings are: Review of Resident #4's current FL-2 dated	D 367	ED, DCS or designee will complete a MAR to cart audit to ensure medications on the MAR match the cart medications as ordered. Complete: 1/15/26 ED, DCS or designee will complete inservice with medtech's to review .1004(j) to support compliance of rule. Complete: 1/30/26 ED, DCS or designee will conduct random audits of orders to ensure .1004 (j) weekly for 1 month. Complete: 1/30/26	

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D 367	Continued From page 9 09/05/25 revealed diagnoses included memory loss, atrial fibrillation, and non-seasonal allergic rhinitis. a. Review of Resident #4's current FL-2 dated 09/05/25 revealed there was an order for warfarin (a blood thinner used to treat atrial fibrillation) 5mg one tablet on Mondays, Wednesdays, and Fridays, and one-half tablet (2.5mg) on Tuesdays, Thursday, Saturdays and Sundays. Review of Resident #4's lab results dated 09/18/25 revealed: -There was an international normalized ratio (INR), a blood test used to monitor the safety and effectiveness of warfarin, result of 3.5. -There were instructions to hold warfarin on 09/18/25 only then resume previous warfarin order. Review of Resident #4's lab results dated 11/13/25 revealed: -There was an INR result of 1.5. -There were instructions to administer 7.5mg of warfarin on 11/13/25 then resume previous warfarin order. Review of Resident #4's lab results dated 11/26/25 revealed: -There was an INR result of 6.2. -There were instructions to hold warfarin for 4 days then resume previous dosing and recheck INR on 12/04/25. Review of Resident #4's October 2025 electronic medication administration record (eMAR) revealed: -There were two entries for warfarin 2.5mg take one tablet on Tuesday, Thursday, Saturday and Sunday.	D 367		

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D 367	Continued From page 10 -There was documentation warfarin 2.5mg was administered twice as duplicate entries on 10/02/25, 10/04/25, 10/05/25, 10/07/25, 10/09/25, 10/11/25, 10/12/25, 10/14/25, 10/16/25, 10/18/25, 10/19/25, 10/21/25, 10/23/25, 10/25/25, 10/26/25, and 10/28/25. -There were two entries for warfarin 5mg take one tablet on Monday, Wednesday, and Friday. -There was documentation warfarin 5mg was administered twice as duplicate entries on 10/29/25 and 10/31/25. Review of Resident #4's November 2025 eMAR revealed: -There were three entries for warfarin 2.5mg take one tablet on Tuesday, Thursday, Saturday and Sunday. -There was documentation warfarin 2.5mg was administered three times daily as duplicate entries on 11/01/25, 11/02/25, 11/04/25, 11/06/25 and 11/08/25. -There was documentation warfarin 2.5mg was administered twice as a duplicate entry on 11/13/25. -There was documentation warfarin 2.5mg was held as ordered on 11/27/25, 11/29/25 and 11/30/25. -There was a separate entry and documentation warfarin 2.5mg was administered on 11/29/25 and 11/30/25. -There were two entries for warfarin 5mg take one tablet on Monday, Wednesday, and Friday. -There was documentation warfarin 5mg was administered twice as duplicate entries on 11/03/25, 11/05/25, 11/07/25, 11/10/25 and 11/14/25. -There was documentation warfarin 5mg was held as ordered on 11/28/25. -There was a separate entry and documentation warfarin 5mg was administered on 11/28/25.	D 367		

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D 367	Continued From page 11 Observation of the medications on hand for Resident #4 on 12/03/25 at 2:45pm revealed: -There was a medication card of warfarin 2.5mg dated 11/03/25 with 3 of 16 tablets available for administration. -There was a medication card of warfarin 2.5mg dated 12/01/25 with 16 of 16 tablets available for administration. -There was a medication card of warfarin 5mg dated 12/01/25 with 12 of 12 tablets available for administration. -The expected amount of warfarin tablets was available for administration if the warfarin 2.5mg and 5mg were administered as ordered. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/03/25 at 3:41pm revealed: -Resident #4 had an active order for warfarin 2.5mg take one tablet daily on Tuesday, Thursday, Saturday and Sunday. -Resident #4's warfarin 2.5mg was dispensed on 09/04/25 for a quantity of 4 tablets, 09/09/25 for a quantity of 16 tablets, 09/29/25 for a quantity of 16 tablets, 10/27/25 for a quantity of 16 tablets and 11/24/25 for a quantity of 16 tablets. -16 tablets of warfarin 2.5mg were a 4 week or 28-day supply. -Resident #4 had an active order for warfarin 5mg take one tablet daily on Monday, Wednesday and Friday. -Resident #4's warfarin 5mg was dispensed on 09/04/25 for a quantity of 3 tablets and on 09/09/25, 09/29/25, 10/27/25 and 11/24/25 for quantities of 12 tablets. -12 tablets of warfarin 5mg were a 4 week or 28-day supply. -The warfarin 2.5mg and 5mg refills matched what Resident #4 should have gotten if the	D 367		

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D 367	Continued From page 12	D 367		

medications were administered as ordered.
-The pharmacy placed order entries on the eMAR.
-He thought the facility could change administration times by a few hours for medications.
-Warfarin should not be showing multiple order entries on the eMARs for the 2.5mg or 5mg doses.

Telephone interview with a representative for Resident #4's primary care provider (PCP) on 12/04/25 at 11:18am revealed she expected the facility to document Resident #4's warfarin administration accurately on the eMARs.

Attempted interview with Resident #4 on 12/04/25 at 10:56am was unsuccessful due to resident being out of facility with family members for the remainder of 12/04/25.

Attempted telephone interview with Resident #4's family member on 12/04/25 at 1:30pm was unsuccessful.

Interview with a medication aide (MA) on 12/03/25 at 2:47pm revealed:
-Resident #4's warfarin 2.5mg order entry was shown twice on the eMARs in October and November 2025 but the eMAR was fixed to show only one entry.
-She was only administering warfarin to Resident #4 once daily.

Interview with a second MA on 12/03/25 at 2:52pm revealed:
-Resident #4's warfarin 2.5mg and 5mg order entries were shown on the eMAR twice each but they had been fixed to only show once daily.
-She had always administered Resident #4's

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	HAL041089	A. BUILDING: _____ B. WING _____	R 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND SQUARE	3823 LAWNDALE DRIVE GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 13 warfarin once daily as ordered. Attempted telephone interview with the Resident Care Coordinator (RCC) on 12/04/25 at 2:27pm was unsuccessful. Interview with the Director of Clinical Services (DCS) on 12/04/25 at 1:47pm revealed: -She had noticed there were multiple order entries on the eMAR for Resident #4's warfarin 2.5mg and 5mg. -She was able to have the extra warfarin order entries taken off the eMAR. Interview with the Administrator on 12/04/25 at 2:10pm revealed she did not know there were duplicate order entries of Resident #4's warfarin 2.5mg and 5mg on the eMARs. Refer to the interview with a medication aide (MA) on 12/04/25 at 10:15am. Refer to the interview with the Director of Clinical Services (DCS) on 12/04/25 at 1:47pm. Refer to the interview with the Administrator on 12/04/25 at 2:10pm. b. Review of Resident #4's current FL-2 dated 09/05/25 revealed there was an order for albuterol (a bronchodilator used to treat shortness of breath) 0.5% 2.5mg/3mL nebulizer inhale 1 vial via nebulizer every 12 hours. Review of Resident #4's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for albuterol 0.5% 2.5mg/3mL nebulizer inhale 1 vial via nebulizer every 12 hours scheduled for administration at	D 367		

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D 367	Continued From page 14	D 367	Type text here	

9:00am and 9:00pm.
-There was documentation albuterol was administered to Resident #4 except for 10/03/25 at 9:00am with documentation of Resident #4 out of facility and 10/25/25 at 9:00am with documentation the order was discontinued.

Review of Resident #4's November 2025 eMAR revealed:
-There was an entry for albuterol 0.5% 2.5mg/3mL nebulizer inhale 1 vial via nebulizer every 12 hours scheduled for administration at 9:00am and 9:00pm.
-There was documentation albuterol was administered to Resident #4 except for 11/18/25 at 9:00am with documentation of Resident #4 out of facility and 11/20/25 and 11/26/25 at 9:00pm with documentation that Resident #4 no longer had the nebulizer machine.

Review of Resident #4's December 2025 eMAR revealed:
-There was an entry for albuterol 0.5% 2.5mg/3mL nebulizer inhale 1 vial via nebulizer every 12 hours scheduled for administration at 9:00am and 9:00pm.
-There was documentation albuterol was administered to Resident #4 on 12/01/25 and 12/02/25.

Observation of the medications on hand for Resident #4 on 12/04/25 at 10:10am revealed there was a bag of albuterol vials with a label dated 09/04/25 with 54 of 60 albuterol vials remaining available for administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/03/25 at 3:41pm revealed:
-Resident #4 had an active order on file for

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D 367	Continued From page 15 albuterol 0.5% 2.5mg/3mL nebulizer inhale 1 vial via nebulizer every 12 hours. -Resident #4's albuterol was last dispensed on 09/04/25 for 60 vials which was a 30-day supply. -Resident #4's albuterol would have run out in October 2025 if it were administered as ordered. Telephone interview with a representative for Resident #4's primary care provider (PCP) on 12/04/25 at 11:18am revealed: -Resident #4's albuterol order was discontinued on 09/17/25 and was not an active order. -She expected the facility to document Resident #4's albuterol accurately on the eMAR; albuterol administration was still being documented on the eMARs although it was not being administered. Attempted interview with Resident #4 on 12/04/25 at 10:56am was unsuccessful due to resident being out of facility with family members for the remainder of 12/04/25. Attempted telephone interview with Resident #4's family member on 12/04/25 at 1:30pm was unsuccessful. Interview with a medication aide (MA) on 12/04/25 at 1:25pm revealed she did not know Resident #4's albuterol order was discontinued on 09/17/25. Attempted telephone interview with the Resident Care Coordinator (RCC) on 12/04/25 at 2:27pm was unsuccessful. Interview with the Director of Clinical Services (DCS) on 12/04/25 at 1:47pm revealed she did not know Resident #4's albuterol order was discontinued on 09/17/25 and was still being documented as administered on the eMAR.	D 367		

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D 367	Continued From page 16 Interview with the Administrator on 12/04/25 at 2:10pm revealed she did know that Resident #4's albuterol order was discontinued on 09/17/25 and was still being documented as administered on the eMAR from October 2025 to December 2025. Refer to the interview with a medication aide (MA) on 12/04/25 at 10:15am. Refer to the interview with the Director of Clinical Services (DCS) on 12/04/25 at 1:47pm. Refer to the interview with the Administrator on 12/04/25 at 2:10pm. Interview with a medication aide (MA) on 12/04/25 at 10:15am revealed she was able to approve order entries in the eMAR system. Interview with the Director of Clinical Services (DCS) on 12/04/25 at 1:47pm revealed: -The pharmacy put order entries on and took order entries off the eMAR. -She faxed new orders to the pharmacy. -The MAs were able to document duplicate order or document not administered for duplicate order entries on the eMAR. -The MAs would be responsible for documenting accurate medication administration. -She supervised the Resident Care Coordinator (RCC). -The facility did medication cart audits at least monthly with cycle fill (when a new batch of medications arrived from the pharmacy. -A medication cart audit consisted of staff looking for expired medication and checking medication labels. -She thought no one had completed medication order audits to compare the eMARs to resident	D 367		

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D 367	Continued From page 17 orders to medication on the cart. Interview with the Administrator on 12/04/25 at 2:10pm revealed: -The pharmacy managed all order entry, order changes and discontinuations. -The RCC and DCS were expected to do medication cart audits monthly. -The RCC and DCS were expected to do monthly medication order to eMAR to cart audits. -She did not know the last time a medication order to eMAR to cart audit was completed. -The MAs on the medication cart were responsible for documenting accurate medication administration.	D 367		